Tobacco cessation program implementation—from plans to reality: skill building workshop—network model

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The following article describes highlights from the skill building workshop "Program implementation—from plans to reality". This workshop was conducted by Sallie Dacey, Group Health Cooperative of Puget Sound, and Risé Krejci, Pacific Health Systems.

PacifiCare Health Systems, Inc (PHS) addresses key health issues through the research and development of health improvement strategies designed to complement the care provided by a robust network of dedicated health care providers. To address the national health care need to reduce smoking prevalence, PacifiCare developed the StopSmoking Program, a tobacco control program based on the theoretical behaviour change model. The StopSmoking program is designed as a self directed, multicomponent intervention utilising telephonic case management, and includes a "quit kit" consisting of self help "quit" booklets, videotape, audiotape, and "urge tamer" tools. Each participant receives an average of 7–14 support telephone calls by a trained smoking cessation counsellor for a period of one year. Currently, the program has a one year, self reported quit rate above 40% (smoke free for the previous 30 days at 12 months).

PHS is one of the nation's leading managed health care services companies. Primary operations include managed care products for employer groups and Medicare beneficiaries in nine states and Guam serving approximately 3.6 million members. Other specialty managed care operations include life and health insurance, behavioural health services, dental and vision services, pharmacy benefits management and Medicare+Choice management services. The PHS vision is to represent "an organisation of dedicated people committed to improving the quality of those lives we touch".

The purpose of the workshop is to define the basic steps for implementing a tobacco control program in a network model, managed care organisation. I will describe what PacifiCare feels are the keys to a successful implementation and will provide a sample of an implementation project plan incorporating these steps.

There are several steps that are key to a successful tobacco control program implementation in a network model health plan. Some of PacifiCare's key observations for implementation are listed below.

Obtain executive/clinical leadership and support
There is a need to provide evidence based research, program design, and budget and cost benefits to medical directors, pharmacy directors, and executive management. This may take several "audiences" with leadership, so be persistent in your campaigning and be prepared. Know how your efforts will impact the "bottom line" and stress the importance of collaboration with providers. Evaluate "process" integration opportunities within your health plan system or already existing disease management and health improvement programs.

Consider effective program design
I recommend you review the Agency for Health Care Policy and Research smoking cessation guideline as a blueprint for your program design. Consider an alternative program design from the tobacco programs already offered by physicians, contracted hospitals, and community resources that could ultimately reach a broad population. Define your program goals, objectives, and measurable outcomes. PacifiCare determined that a program delivered telephonically would reach a broad population and help support our goals. Our program focus was to develop "tools" that would help empower the individual to quit smoking through healthy lifestyle modifications that increase the individual's belief in his ability to manage his life positively without tobacco products. Emphasis on developing a self paced program that can be tailored to the participants' readiness to quit was a core strategy for promoting behaviour change, reinforced by providing personalised telephone support by a trained smoking cessation counsellor.

Provide covered smoking cessation aid and program benefit
We assessed the impact of charging a program fee to participants based on some of the preliminary research regarding cost barriers. We concluded that a small co-pay could potentially enhance compliance by requiring a small investment by our participants. We charge a small co-pay of $20 to enroll in the StopSmoking program. It obviously does not offset our program delivery cost, but the amount has not appeared to be a cost barrier to our members. Our participation grew significantly when we tied a covered smoking cessation aid benefit to the StopSmoking program. Currently, most of our markets cover a nicotine patch and/or non-nicotine therapy product. This benefit is the "carrot" that draws most members to the

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program; however, they are **only** eligible for the smoking cessation aid benefit if they participate in the StopSmoking program and telephone counselling component. The participant is responsible for a small co-payment per prescription ($20 and under).

Focus on physician referral process, support, and education

There are many challenges to implementing a successful physician referral process in a network health plan model; however, it is critical to the success of any of our interventions. We continuously evaluate opportunities to educate our network providers about our tobacco control program and to develop referral processes that are simple and require little time on behalf of the provider. Most promotion to physicians occurs through targeted mailings, provider publications, and face to face contact by dedicated health improvement market staff. Our health improvement staff collaborates with our provider services teams to present our tobacco control program at joint operating committee meetings or other clinical meetings. StopSmoking program brochures, chart stickers, referral forms for fax and prescription pads, are all provided to our primary care physicians for distribution at their clinic. We also solicited the feedback of some of our providers during the development of our program.

Focus on convenience and accessibility of the program to a broad population

This is a key concern for any program. By providing our program telephonically, we reduced any geographic barriers and provided an alternative to class based programs available through our providers, hospitals, and community resources. The flexibility of scheduling one-on-one "counselling support" appointments based on the member's availability is a true value for our participants.

Provide centralised and integrated delivery system

We found that delivering our services as a centralised model enhanced our staff and other delivery efficiencies, thereby reducing costs. Our outbound calls by counsellors in California must serve members who reside in three time zones, but we maximise costs by using one toll free enrollment number. This also assists in our marketing efforts. We are able to develop materials that can be used by all markets and so we benefit from bulk printing costs. By assembling our staff at one location we can monitor performance and provide consistent training and supervision. The staff also serve as mentors or support for one another when addressing counselling issues or training new employees. In addition to the centralised delivery team there are other key staff who are important to the success of our program implementation and delivery. Our regional health improvement staff manage the implementation and internal/external communication at a local level, and report to the corporate central team the aggregate results. The regional health improvement staff also work closely with other local internal departments who assist in implementation, such as customer service, legal and regulatory affairs, sales and marketing, provider services, providers, and public relations/communications.

Identify key stakeholders and their accountabilities

In our system, we have multiple "health improvement" stakeholders, both at a corporate and regional level. Implementation for a centralised, national program must integrate the needs, ideas, and suggestions from all stakeholders in order to meet the goals of a successful implementation. Our company tends to approach most implementation as a "one company approach"; however, some flexibility for customisation must exist to meet the needs of an individual market. In the early phase of developing our program implementation strategies we develop a project plan which identifies each stakeholder, deliverables, key milestones, and accountabilities. Regular, ongoing communication during implementation is key so we schedule meetings to discuss outcomes, updates, and requests for process improvements. These discussions are also documented so we can distribute notes to other stakeholders or staff affected by the implementation.

Consistent, frequent follow up and "coaching" beyond quitting by credible staff, and appropriate staff to member ratio

This actually addresses a program design concern, but also affects the overall success of the program. Consistent "one-on-one" coaching by a trained cessation specialist is paramount to the members' success, and we believe this is the reason we have maintained quit rates above 40% at one year. In addition, to reduce relapse rates we provide outbound calls to the participant between the six and 12 month period where the greater risk of relapse may occur. We utilise a variety of professional staff with different educational experiences. All staff have either an undergraduate or graduate degree in public health, health education, or other related degree. Some are registered nurses, and others have worked as crisis counsellors or with 12 step programs. Determining the appropriate staff ratio to member depends on the average amount of time the counsellor spends with the participant. We consistently evaluate counsellor performance and time spent on calls. I recommend that you provide call parameters, which should include preferred length of call and an "outbound call" outline to guide content and focus of calls. Again, these are just used as guidelines as the key to coaching is to provide individualised support. As our counsellors gain more experience they become more efficient and improve the quality of their call; they also increase the number of clients they support.

Table 1 PacifiCare StopSmoking implementation plan (draft). MCO network model

Action item		Owner	Start date	Due date	Comments/updates
1	Conduct needs assessment by market				Establish appropriateness of implementing programs, ie, % of members that smoke, % of Spanish speaking members, high risk segments, etc
2	Develop goals and objectives for the program				Meeting NCQA/HEDIS initiatives, decreasing smoking prevalence, decreasing medical costs, added value to PacifiCare PMG's, increase PMG referral, added value to PacifiCare clients (employers), etc
3	In conjunction with developing the goals and objectives, identify targeted populations				ie, Secure Horizons, commercial, adolescents, high risk: diabetics, heart failure, acute myocardial infarction, pregnancy, etc
4	Determine program evaluation process				Provide employer, provider, member data and quit rate reports in aggregate and by market. Develop program database for tracking progress and measurable results
5	Develop marketing and communications plan				Determine strategy of promotion to providers, members and employers
6	Assess pharmacy benefit options in support of a covered smoking cessation aid				Determine if nicotine patches are currently a covered benefit. Assess feasibility/cost of covering smoking cessation aids as part of the StopSmoking program
7	Assess filing program as core or added value benefit. Determine member co-pay				Present and discuss with commercial and government agencies, benefits administrators/committees
8	Identify regulatory agencies by market that need to be involved				HCFA, DOC, DOI, etc
9	File programs/promotion with regulatory agencies				Provide program overview/materials to corporate legal and regulatory (L&R) affairs, corporate L&R to facilitate regional L&R communication, market program manager to facilitate internal/market L&R communication
10	Determine method of program enrollment for the StopSmoking program				Enrollment process options. First option: member calls customer service. Information which would need to be collected includes: member name, member number, member date of birth, member mailing address, and member telephone number. Customer service would then fax the enrollment information to StopSmoking operations. The second option for enrollment is to distribute postage paid/self addressed enrollment cards that the member fills out and returns to market. Third option: member self refers and calls directly into a dedicated 800 line
11	Determine staff/operations needs				Identify corporate program manager responsible for product delivery, promotion, market contact, provider services contact, counsellors, enrollment specialist, etc
12	Develop budget				Program delivery costs, promotion, Rx (NRT) benefit, staff recruitment and training, % of members who smoke/participation rates, etc
13	Identify internal training/communication needs				Customer services, providers services, sales/marketing, PMG/IPA's, medical directors, QI, etc
14	Establish time line/milestones for implementation of the StopSmoking program				Based on regulatory filings, time line on presenting StopSmoking program to medical groups, coordinate with member publications advertisement, etc
15	Identify medical groups to pilot program delivery and support				Select and prioritise medical groups to support pilot
16	Promote StopSmoking program in member and provider publications				Work with PHS corporate communications, frequency and topic focus
17	Develop and print collateral marketing materials for employers, health fairs, provider offices, sales/marketing, etc				Determine what quantity and items required for program promotional materials (brochures, overviews, Rx pads, chart stickers, poster, etc)
18	Identify information services corporate and market contacts				Support for member validation, database maintenance, program reporting

Develop internal/external communication plan and strategy

Developing an internal and external communication plan early in your implementation planning is recommended. Determine which internal staff and departments will be affected by or will support your program implementation. Who are your customers and constituents? It is very important that you include your sales/marketing and public relations staff as they are key to communicating externally to your purchasers of the health plan. Customer service is also another important department and typically the primary information source for your members, especially as you first roll out your program. Be sure to also engage your physicians to encourage physician referral and the National Cancer Institute's "4A" model of interaction. Your implementation timelines can be slowed down by not communicating to key stakeholders early in your implementation efforts. Consider all your promotion options such as email, newsletters, meetings, publications, etc, and how this impacts your overall communication strategy internally or externally.

Ongoing, multiple promotion and reinforcement

Ongoing promotion increases awareness and utilisation of your program. We have learned that it is necessary to apply multiple promotion strategies—repeat your efforts and often. Consider multiple methods of promotion such as targeted mailings, newsletters, brochures, and publications, open enrollments, health fairs, "on hold" phone messages, and public presentations. Send a brochure to a smoker identified through a health questionnaire. Target high risk populations such as members with diabetes, cardiovascular disease, or pregnancy through hospitalisation, pharmacy, or claims data. Most of our promotion efforts target the members. Continuous promotion and reinforcement is necessary and will take time to affect your utilisation, so be patient and be creative in your efforts!

Measure processes and outcomes. Make continuous quality improvement analysis a priority

The three key areas we evaluate after program implementation are utilisation, member/provider satisfaction, and quit rates. Also, we continuously re-evaluate our program effectiveness in the areas of implementation, data collection, staff, and operational integrity and effectiveness. This is most important following your initial implementation to determine if all action items were accomplished and milestones were achieved for a successful and

timely program roll out. Reassess your original implementation project and determine its impact and if your goals were met. Try to anticipate the need for developing new processes as your program matures and newer technologies emerge. Be flexible in assessing and developing process improvements that will affect program efficiencies and support enhanced participant satisfaction. Query your participants by distributing a program evaluation to determine satisfaction level and what they value about your program features. In addition, we measure participation and outcomes based on quit rates.

Automate administrative tasks but keep the human touch

We have developed a database for programmatic tracking, utilisation, and reporting, and provide an online system that our counsellors can use when counselling and tracking the progress of participants. This "paperless" system enables our staff to be more efficient in their use of time and helps control our costs, as well as benefit our participants. By reducing "manual" administrative tasks, our staff can spend more quality time with the participant on the phone and less time on tracking data that is imperative to determining our program effectiveness.

Summary

The keys to a successful tobacco control program implementation will vary based on the health plan delivery model. The steps presented today focused on an implementation strategy recommended and tested for a network model. Keys to our success included developing a plan and strategy that integrated regional and corporate stakeholders, consistently evaluating our processes and outcomes, and persistent promotion and reinforcement of the benefits of a tobacco control program to our providers and constituents. I have provided a sample implementation project plan highlighting the primary steps to implementation at a high level to help you get started (table 1).

Questions and answers

Q: Are there confidentiality issues with telling a physician in your network that your member is enrolled in the program and what their smoking status is?

A: Our smoking cessation counsellors will inform the participant during the first counselling appointment that a letter will be sent to their physician informing them that they enrolled in the program. We send a form letter to the Primary Medical Group informing them that this patient has enrolled in our program. We also send quarterly participation reports that list participant by group and their smoking status. We have not experienced any adverse reactions from our participants about informing their physician. Occasionally the participant will ask whether we are sharing this information with their employer, which we do not on an individual level. Confidentiality has not been an issue.

Q: Do you know that the physicians are actually using the information you provide to them? In other words, when they get a report on their patients, do they actually talk to them about quitting when they see them?

A: We don't actually track or follow up with the provider specifically to determine what they do with the information. However, they have indicated that they want us to inform them if our members enroll. We assume they will be reminded that their patient is participating in our program if they include our letter in the patient chart. We also collect some feedback about their awareness of our program from satisfaction surveys or in their discussion with the regional health improvement staff.

Q: Is the content of your program tailored specifically for participants with other health conditions, such as pregnancy, diabetes, heart disease, etc?

A: Our smoking cessation counsellors' training and experience allows them to tailor their counselling based on current health status. Most of our participants who enroll in the program will have other health issues such as pregnancy, depression, or a chronic condition such as cardiovascular disease or diabetes. We have additional self care materials developed to help educate the participant on lifestyle behaviours they can control for diabetes, pregnancy, depression, and cardiovascular disease. The primary focus of the counsellor is supporting the participant's first goal to quit smoking; but, they can also provide counselling in the areas of exercise, nutrition, stress management, understanding symptomology, and medication compliance as appropriate by health condition.